

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005388

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

298

STATE FILE NUMBER

FILED MAR 11 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri - b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 10 days	c. CITY OR TOWN Faucett Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Medical Cen.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MABEL GEORGIE REYNOLDS		4. DATE OF DEATH Month March Day 3 Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/10/1883
9. AGE (last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Blue Rapids, Kansas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Noah M. Latchaw	
13b. MOTHER'S MAIDEN NAME Minnie B. Roberts		14. NAME OF HUSBAND OR WIFE Lawrence L.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no		16. SOCIAL SECURITY NO. Lawrence Reynolds, Faucett, Mo.	
17. INFORMANT Lawrence Reynolds, Faucett, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pneumonia, atypical, viral DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 14 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb. 23, 1963 to Mar. 3, 1963 and last saw her alive on Mar. 3, 1963 Death occurred at 9:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree, or title) William P. Mc Donald		22b. ADDRESS M. D. 301 N. 8th St., St. Joseph, Mo.	
22c. DATE SIGNED 3/5/63		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/5/1963	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph Missouri
24. FUNERAL DIRECTOR Hester - Bowman		25. DATE RECD. BY LOCAL REG. Mar. 8, 1963	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

W.P.M. Donald, Registrar

USE BLACK INK
OR
TYPEWRITER RIBBON

10-10-10-10-10

10-10-10-10-10

Permit issued 3-11-63

11-10-10-10-10

11-10-10-10-10

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

William Spalding

Licensed Embalmer No. 4535

P. O. Address

319 1st St
St. Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.